Intervention in Elder Mistreatment

This research brief synthesizes scholarship in the area of elder abuse intervention. With increasing awareness of the significance of elder mistreatment (EM), the need for effective, individual, community, and societal level responses is clear. Yet, despite the prevalence of abuse, the literature does not reflect an overall increase in the number of new interventions. Additionally, there are few high-quality studies evaluating the effectiveness of existing intervention and prevention models and measuring their impact on elders.[1] Efficacy research is needed to better inform practice applications and policy initiatives to optimize outcomes for older adults who have experienced abuse.[2] Intervention models are still largely lacking in an evidence base, but a number have demonstrated potential. This brief will address areas of intervention research and highlight several of the established programs, innovative strategies, and promising practices in the field.

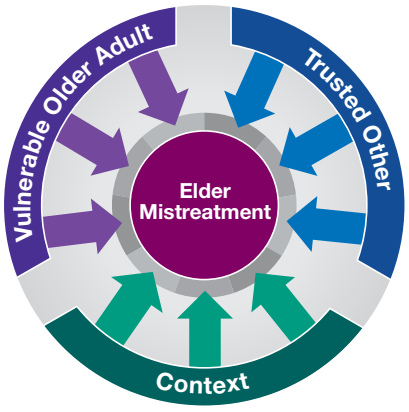
KEY TAKEAWAYS

- The majority of EM interventions involve education and multidisciplinary team development
- Financial exploitation and physical abuse are the most common forms of mistreatment targeted in interventions, with 75% of interventions addressing multiple forms of mistreatment rather than one type
- More programs focus on intervention, rather than prevention or identification
- APS is the most widely used intervention to address EM
- Few interventions use a rigorous study design and fewer still demonstrate significant measurable impact[3]
- Person-centered, goals-driven, and tailored approaches may increase uptake and improve outcomes among older adults[4]
- Effective interventions require a multi-modal effort that targets older adults and offenders across individual, community, and societal systems and domains of awareness, knowledge, and behavior[5]

Theory

The ecological-systems theory has been the predominant theory to conceptualize the complex, multifaceted risk factors associated with EM. As envisioned in the **Elder Abuse Theoretical Risk Framework** posited by the National Research Council in 2003, predictors of risk are associated with individual, relational, and socio-cultural eco-systemic levels.[6]

More recently, the **Abuse Intervention/prevention Model (AIM)** recognized three related domains in understanding EM: the vulnerable older adult, the trusted other, and the context of their relationship. Risk factors specific to each domain, operating independently and in combination, are associated with an increased likelihood of abuse occurrence.[7] Applying a risk management approach to mitigate harm, strategies can be implemented to defuse modifiable risk factors for EM, such as increasing protective social supports for older adults with limited networks. Similarly, approaches may be used to mediate nonmodifiable predictors of abuse,[8] like medication or therapeutic remedies for chronic medical conditions. Research suggests that effective intervention approaches should have the capacity to work with both the older adult and the family perpetrator to reduce EM risk and strengthen social systems surrounding the victim-perpetrator dyad.[9]



Building upon the ecological model, a third construct, the **Contextual Theory of Elder Abuse**, advances four main spheres of influence that impact EM occurrence: the individual context, the relational context, the community context, and the societal context. This model posits that EM occurs against a backdrop and at the intersection of the elder's personal characteristics, relational ties, community integration, and societal norms, which in combination, contextualize the causal factors associated with maltreatment by trusted others and strangers.[10]

Strategies

Several strategies have been proposed to guide EM interventions, including the development of person-centered approaches, goal-attainment scaling, a severity framework, and trauma-informed care models.

PERSON–CENTERED APPROACHES

Optimally, interventions should be person-centered, person-directed, and self-determined, integrating the older adult's preferences and values. This approach recognizes the elder's autonomy, the right to make decisions, and define their preferred resolution outcomes. Person-centeredness embraces an individual's culture, race, ethnicity, ability, gender identity and expression, sexual orientation, faith, and other intersectional identities. Cultural sensitivity is particularly significant in working with diverse communities that have been historically marginalized.[11]

GOAL–ATTAINMENT SCALING

Goal-Attainment Scaling is a process by which older adults who have experienced EM identify their own goals and measures of successful outcomes. This approach aligns with a person-centric ethos as practitioners working with elders elicit their clients' preferences, values, and desired outcomes, even if they differ from societal goals or a provider's presumed course of action.[12] Interventions are responsively tailored to self-determined objectives, optimizing elder agency and rights as well as the efficacy of the services provided.

SEVERITY FRAMEWORK

Researchers have suggested the adoption of a severity framework to guide outcome measurement.[13] Traditional measures of intervention have evaluated effectiveness using a "yes" or "no" approach. This construction does not contemplate the complexities of EM and the incremental changes that may occur over the course of an intervention that do not fit neatly into a binary paradigm. A severity model aligns with a person-centered approach, assessing the extent to which the intervention mitigates the multifactorial aspects of EM, including the frequency and severity of harm experienced.[14]

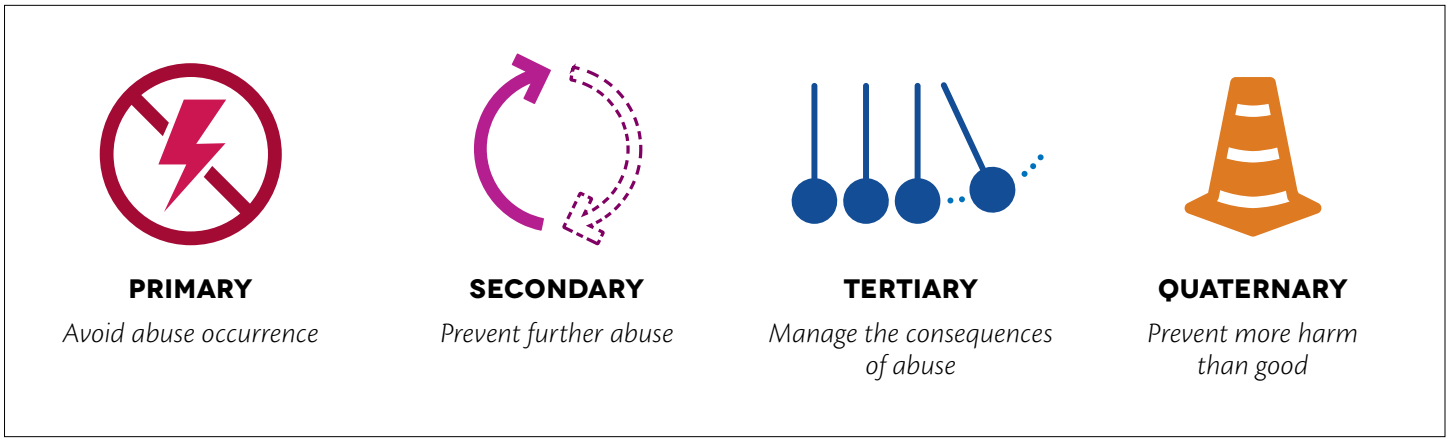
TRAUMA–INFORMED CARE

Research suggests that violence beginning in childhood and continuing over the life course may elevate the risk of abuse in older age. There is a strong correlation between child and adolescent maltreatment and persistent violence in adulthood. Intersecting forms of abuse into elderhood are less studied and documented, but probable.[15] Trauma-informed care has been proffered as a means to inform EM interventions by recognizing and allaying the impact of historical traumas on older adults experiencing EM.

Trauma-informed interventions integrate six guiding principles: (1) safety; (2) trustworthiness and transparency; (3) peer support and mutual self-help; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues. This holistic model is intended to embolden older adults by facilitating help-seeking behaviors and personalized interventions.[16]

Intervention Classifications

Interventions can be classified as **primary**, **secondary**, **tertiary**, and **quaternary**. Most fall within the first three categories. Primary preventions are designed to avoid abuse occurrence and focus on eliminating risk factors that may portend mistreatment. Secondary preventions aim to prevent further abuse or harm through early detection and response to EM, while also targeting risk factors associated with EM. Tertiary preventions manage the consequences of elder abuse. Less frequently observed in practice, quaternary prevention are mechanisms to prevent more harm than good.[17]



PRIMARY PREVENTION

Risk Assessment and Screening

Risk assessment and screening happen across prevention domains. Screening instruments are standardized protocols that may assist providers in identifying the risk or presence of abuse. Several assessment tools have been and are being developed for use in health care, legal, and social service settings to identify at-risk elders. Tools must be tailored to the setting, the population, and utilized in combination with observation and expert evaluation.

Advance Care Planning

Advance care planning tools enable individuals to specify a plan for future health care and financial decision making in the event that they become incapacitated and are unable to make their own decisions. Advance planning can help ensure that older people's preferences and values are communicated, legally documented, and translated into practice by a trusted designate.[18] The Consumer Financial Protection Bureau provides information and resources to guide consumers with advance planning.[19] Instruments including advance directives, powers of attorney, and supported decision-making agreements, may reduce the risk of abuse and exploitation. Importantly, they may also be used as instrumentalities of mistreatment.[20] Financial management and oversight is a related primary prevention that has had some support in the literature.[21]

Education and Awareness

Education is one of the most prevalent forms of primary prevention.[22] Programs address all types of abuse, across disciplines and eco-systemic domains, from the societal, organizational, to interpersonal levels. Education and training have been associated with increased knowledge among older adults and professionals, greater identification of EM, and management of mistreatment. Within the primary health care service domain, one research review found that didactic training enhanced knowledge and awareness of EM, but alone was insufficient to impact EM behaviors.[23]

Educational interventions include:

- Caregiver psycho-educational programs[24]
- Educational programs for professionals and practitioners[25]
- Intergenerational programs that address ageism and social isolation[26]
- Co-designed digital storytelling that gives agency to older people's voices in program development[27]
- Elder financial education[28]
- For health care professionals, effective strategies include didactic education coupled with standardized patient cases, patient assessment in cases of EM, training from experts in the field, and home visits[29]

Community awareness campaigns are another approach to enhance understanding of EM. **World Elder Abuse Awareness Day (WEAAD)**, celebrated across the United States and internationally since 2006, continues to be an annual platform for global awareness, recognition, and engagement.[30]

Anti-Ageism Communication Strategies

Ageism is the stereotyping, prejudice, and discrimination of people on the basis of age. Biased attitudes and beliefs about older people can lead to harmful social, health, and economic consequences. They may also activate EM or provide an environment in which it is more likely to occur.[31] Communication strategies focused on disrupting ageist misperceptions of older age by framing aging as a positive experience can be an effective primary prevention.[32] The **Reframing Aging** and **Reframing Elder Abuse** initiatives posit a solutions-oriented approach to age-bias highlighting the values of justice, equity, inclusion, and solidarity by framing age-bias as a community-wide, shared concern.[33] The Reframing campaign suggests promoting elder capabilities and contributions through public awareness, positive messaging, and education to shift the public's understanding of age equality.

Culture Change

Policies that promote safety and independence for older adults in community and long-term care settings provide protections. Formal legislation and informal protocols can foster positive attitudes of aging and address gender inequality and other forms of discrimination that can drive EM.[34]

Strengthening Economic Supports for Families

A prevention strategy with the potential to prevent multiple forms of violence involves strengthening economic supports for families. Studies have suggested that policies and practices that increase financial security may reduce rates of EM.[35]

Social Support

Low social support has been identified as a significant risk factor for abuse across types.[36] Embeddedness within social, community, or faith-based networks may serve as a protective mechanism to help prevent EM.[37]

SECONDARY PREVENTION

Risk Assessment and Screening

Screening and assessment are considered best practice preventions.[38] Researchers recommend the development of concise tools, easily administered by trained providers, that align with referral pathways and intervention strategies.[39] Though several tools have been tested and some validated, there is no gold standard that definitively detects the presence or absence of abuse. A reference standard may be difficult to achieve given varying legal definitions of abuse, the range of clinical settings and patient conditions, and the overlap of signs of abuse with markers of disease.[40]

In addition, existing instruments purport to detect the presence or absence of EM, rather than the change in status over time through a severity construct, inhibiting accurate outcome measurement. Validity testing of instruments is needed, particularly within different cultural contexts, across diverse patient and professional settings.[41]

EXAMPLES OF SCREENING TOOLS

- **Tool for Risk, Interventions, and Outcomes (TRIO)** for use in Adult Protective Services (APS)[42]
- **Elder Abuse Risk Assessment and Evaluation© tool (EARAE)**[43] developed for case workers in the aging services field outside of APS
- **Elder Abuse Suspicion Index (EASI)**[44] for use in primary care
- **Elder Mistreatment Screening and Response Tool (EM-SART)**[45] developed to assess the risk of abuse in the emergency department

Practice Guidelines

Assessment guidelines and protocols have been developed to facilitate elder abuse detection and management.

The American Medical Association's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect was designed to help medical professionals identify EM and integrate assessment into clinical practice.

The **APS Risk Assessment Protocol** was developed by the US Adult Protective Service program to document and track the risk of recidivism in older adults.[46]

"Legal Issue Spotting, Intake and Referrals Practice Guide" is another useful resource intended for civil attorneys.[47]

Adult Protective Services

APS is the most widely used intervention to address EM. The agency investigates allegations of EM and facilitates a range of person-centered remedies for older adults experiencing abuse. Services include client needs assessment, development and implementation of care plans, and service provision and referral.[48]

APS originated in the early 1960's. In 1962, the Public Welfare Amendments to the Social Security Act authorized states to establish protective services for adults unable to manage their affairs or who experienced abuse, neglect, or exploitation.[49] In the latter part of that decade, seven federally funded adult protective services demonstration projects were conducted in cities across the U.S. The results of those projects served as an impetus for federal funding to states to develop programs as provided in Title XX of the Social Security Act of 1974.

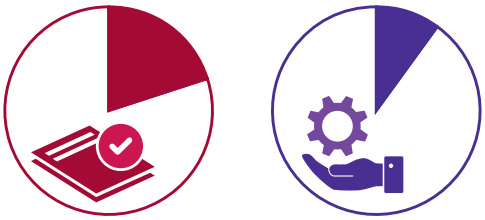
Each state has its own APS organization, variously administered by state and/or local governments.[50] Programs differ among states and between counties regarding client eligibility and available resources. All states, except New York, require certain professionals who are designated by state statute to report incidents of suspected EM to reporting agencies, including APS. Mandatory reporters may include healthcare professionals, social service providers, caregivers, clergy, and financial institutions, among others.

Generally, individuals who have experienced abuse must consent to APS services and interventions. Older people with decisional capacity may decline APS assistance. Under certain circumstances, APS may render involuntary protective assistance to individuals who lack capacity or when the exigencies of the situation require intervention.[51]

In 2019, APS received over 1.3 million reports of alleged maltreatment. Approximately **260,000 allegations were investigated and substantiated**. **Service was provided in almost 130,000 cases**. Though trends suggest that reports and caseloads are increasing, as with other EM interventions,[52] there is insufficient evidence to determine the efficacy of APS interventions on client outcomes, though researchers continue to search for valid methods to measure program effectiveness.[53]

The **Administration for Community Living (ACL)** is facilitating an APS Research Agenda to provide guidance to researchers, APS programs, and funders to highlight research gaps and build a cohesive body of evidence for the APS field.[54]

CASES OF ALLEGED MALTREATMENT REPORTED TO APS



Investigated and substantiated

Service provided

LONG-TERM CARE OMBUDSMAN PROGRAM

Long-term care ombudsmen serve as advocates for residents in long-term care facilities. With resident consent, they investigate allegations of abuse, help resolve complaints, protect their resident rights, and work to improve systemic problems in long-term care.[55]

The **Long-term Care Ombudsman Program** was authorized in 1978 under the Older Americans Act to establish a consumer advocacy program intended to maintain and/or improve the life quality for residents of long-term care facilities.[56]

Over 198,502 complaints were investigated by the Ombudsman program in 2019. That year, more than 425,084 people sought and received information on long-term care.[57]

SECONDARY/TERTIARY PREVENTION

The following interventions may occur along the secondary or tertiary stations of the prevention spectrum.

Risk Management for Recurrent EM

Factors that impact recidivism and impede resolution are particularly relevant to intervention strategies. Recurrent maltreatment may be related to the risk factors that first incited the EM, but they may also be associated with perpetuating and confounding factors. These may include the elder's characterization of the conduct as EM, the degree to which conduct is excused, the parties' receptivity to help, and barriers to service utilization.[58]

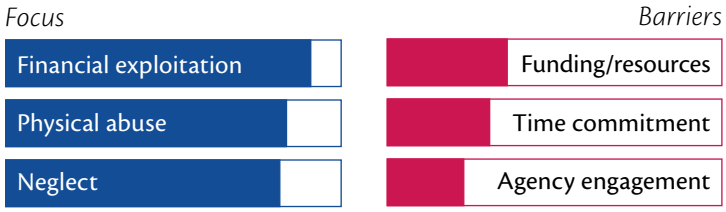
Multidisciplinary Teams

Given the multifactorial nature of EM, an effective EM response requires input across disciplines. Multidisciplinary teams (MDTs) gather interagency expertise to evaluate complex cases of EM. Two robust models grew out of the MDTs, Elder Abuse Forensic Centers (EAFC)[59] and Enhanced Elder Abuse Multidisciplinary Teams (E-MDTs),[60] characterized by coordinated and person-centered case review and intervention in ongoing cases of EM. The structure and function of MDTs differ depending upon community need and available resources. Members may include health care practitioners, mental health services, victim services, civil legal aid, prosecutors, Adult Protective Services, ombudsmen, and financial services providers.[61]

Some EAFCs and E-MDTs retain Service Advocate/Elder Advocate, social workers who help facilitate the person-centered preferences of older adults through case management and safety planning following EM.[62]

MDTs have variously been described as a gold standard[63] intervention and a promising practice.[64] There are nearly 400 MDTs nationwide. The majority focus on financial exploitation (90.8%), followed by physical abuse (83.58%) and neglect (81.59%). The most frequently perceived barrier to MDTs was funding/resources (35.8% of teams), time commitment (30.56%), and agency engagement (22.84%).[65]

Multidisciplinary teams (MDTs)

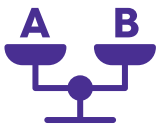


Capacity Assessment

A capacity assessment is conducted by a trained professional to evaluate whether an older person has the ability to make decisions in their own behalf. Specifically, whether they have the ability to:[66]

Understand information related to an issue

Appreciate the situation and the impact of their decision



Reason and weigh available options

Communicate their decision

Assessments can impact next steps for APS or social service caseworkers in developing a person-centered case plan.[67]

Legal Support

Legal interventions include both civil and criminal remedies. Civil legal relief can include explanations of legal rights, assistance with drafting powers of attorney, support with recovering exploited assets, and assistance with preparing petitions for restraining orders and guardianships. Criminal legal remedies include the prosecution of cases of elder mistreatment.[68]

Community-based Interventions

Most community-based interventions are directed to older adults who have been harmed, but some programs are geared to reducing offender-specific risk factors to mitigate EM. For the elder, interventions can include support groups, emergency financial assistance, cultural and faith-based services, food and housing support, safety planning, and medical and mental health treatment. Perpetrators may be able to access social support, mental health treatment, and substance use programs.[69] Educational interventions are often available for older adults, perpetrators, and the professionals with whom they engage.[70] Studies have cited the benefits of multi-component, targeted interventions with the potential to increase program uptake and effectiveness.[71]

HELPLINES

Helplines have been used by older adults, family, and professionals to request guidance, services, and information. Trained helpline responders capture cases that may never be reported to APS or law enforcement agencies, particularly when advice is sought without requesting an investigation.[72]

TERTIARY PREVENTION

Elder Shelters

The Harry and Jeanette Weinberg Center for Elder Justice in New York developed the first elder shelter, providing emergency housing for elders living with EM. The model combines shelter with counseling, social support, health care, legal aid, and advocacy to provide multidisciplinary support for those experiencing EM.[73] Drawing from this model, shelters are being developed in other parts of the country.

Elder Mediation

Elder mediation has been used to reduce family conflict, facilitate communication, encourage offender accountability, and elder empowerment. Led by an experienced elder mediator with specialized training in aging-related issues, the risk factors predictive of abuse, and dispute resolution techniques, elder mediation is a promising practice.[74]

Restorative Supports

Restorative justice is an alternative to criminal justice that promotes repair and healing within the elder/harmer relationship and the larger community. The process enables elders to obtain reparation and closure while the harmer gains understanding of the impact of the offending behavior and accepts accountability for wrongdoing.[75] The RISE model (Repair Harm, Inspire Change, Support Connection, Empower Choice) is a novel approach piloted in Maine that integrates restorative justice principles to address EM risk and strengthen systems of support surrounding the elder and harmer.[76]

QUATERNARY PREVENTION

Only one study has examined quaternary prevention, yet researchers have recognized the potential of interventions to cause more harm than good.[77] For example, negative results may ensue where inappropriate risk assessment has been conducted, confidentiality has been breached, or a safety plan has failed, escalating rather than defusing EM.[78] The potential for harm punctuates the importance of developing interventions with rigorous outcome studies and safeguards.[79]

Long-term Care Interventions

Individuals in long-term care are particularly susceptible to EM because most suffer from cognitive impairment, chronic conditions, and/or physical limitations, factors associated with an increased risk of EM.[80] Interventions proposed to prevent abuse within long-term care facilities include (1) educating staff, particularly focused on the care of residents with dementia; (2) training staff in areas including conflict resolution and stress management; (3) ombudsman oversight;[81] (4) reorganizing the activities and environment in nursing homes; (5) improving conditions through interpersonal support, shared learning, transparency, and person-centered care; (6) encouraging teamwork; (7) improving work conditions; (8) retaining knowledgeable supervisors, increasing oversight, and heightening response during periods of highest EM risk; (9) conducting background checks; (10) using surveillance systems; and (11) improving the governmental response to complaints.[82]

MODEL INTERVENTIONS

CARIE (Coalition of Advocates for the Rights of the Infirm Elderly)
An 8-hour, 8-module training session for staff involving discussion and role-play regarding EM in nursing homes[83]

SANE (Sexual Assault Nurse Examiners)
Training for nurses to assess and care for older victims of sexual assault that incorporates evidence collection and multidisciplinary team coordination to facilitate prosecution[84]

Interventions in Diverse Communities

There is limited research addressing abuse intervention within diverse communities. Much of the literature has focused on White, middle-class elders, exposing an intervention and response gap for diverse elders who experience EM. Appropriate, culturally informed remedies necessitate an understanding across domains of race, ethnicity, gender, sexual orientation, ability, and faith. Cultural values, beliefs, and traditions significantly influence the ways in which EM is defined, perceived, and reported. In communities subjected to historical racism and oppression by law enforcement and criminal justice systems, members may be less apt to report abuse and seek formal helping resources. Limited culturally sensitive services and resources impede resource utilization and intervention.[85]

BARRIERS TO INTERVENTION

Individual, relational, and institutional barriers across the eco-system may hinder help-seeking behaviors by older adults. Help-seeking is significant because it can minimize harm following EM.[86] Yet, research suggests that only 4% to 14% of older adults seek assistance from formal supports such as law enforcement or APS. In addition, access to and the availability of formal interventions such as community-based supports and services are limited. The dearth of culturally acceptable resources may also deter intervention and timely response. For older adults, education about abuse, available services, and the provision of culturally sensitive and trauma-informed supports may help to increase uptake and reduce barriers.[87]

More often, elders reach out to family or friends, which may perpetuate EM. Most offenders are family members or trusted others. Older adults may be reluctant to report family perpetrators because of embarrassment, the need for social/familial connection, fear of retribution, economic dependency, or unwillingness to expose loved ones to legal processes, among other reasons.[88]

Interventions: Research Recommendations

PRACTICE

- Detect and integrate protective factors and modifiable risk factors into intervention strategies[89]
- Involve multidisciplinary and multidimensional approaches to prevention, and build upon existing promising programs including awareness campaigns, shelters, and helplines[90]
- Develop and implement culturally appropriate practices and interventions that target social determinants of health to inform prevention approaches[91]
- Adapt evidence based, culturally informed interventions in geriatric health care and public health practice[92]
- Construct a tool that measures the risk of recidivism, administered at intake and case closure, to assess the degree to which the risk of revictimization has been mitigated through the intervention[93]
- Investigate the possible adverse effects of intervention, the impact on older adults, the clinician provider relationship, and self-reports of abuse[94]
- Increase awareness of recurrent violence, intervention research, and systems integration to reduce polyvictimization over the life course and better serve vulnerable children, youth, and adults[95]

RESEARCH

- Investigate the nexus between intervention activities and the prevention and reduction of EM[96]
- Apply theoretical frameworks in the design and evaluation of interventions[97]
- Examine the protective factors associated with a lower likelihood that EM will occur[98]
- Examine the relationship between violence types and interventions on the causes of violence across the life course[99]
- Facilitate interventions that incorporate multiple spheres of eco-systemic impact[100]
- Model program process outcomes as factors to help mediate or facilitate successful case outcomes[101]
- Establish consistent EM outcome measures across studies to facilitate enhanced data pooling and analysis[102]
- Conduct qualitative studies to solicit elder perspectives and assess the range and nature of program impacts and outcomes[103,104]
- Design mixed methods studies to examine a range of outcomes and capture both quantitative and qualitative data to better understand the effects of EM interventions[105]
- Employ more robust research designs, improve the quality of reporting of findings, and use practice models to inform research[106]

EDUCATION

- Train professionals to identify the signs of EM, recognize the risk factors associated with abuse, understand reporting protocols, and manage an effective response to EM[107]
- Develop intergenerational programs, caregiver psycho-educational programs, and educational programs for professionals[108]
- Educate older people in EM knowledge, coping strategies, empowerment, and resilience[109]
- Increase public awareness of EM[110]
- Integrate cultural awareness and sensitivity in education and training[111]

POLICY

- Dedicate additional funding to the design and development of high-quality EM evaluation research[112]
- Examine the extent to which programs can reduce healthcare costs associated with EM[113]
- Implement policies and practices that improve household financial security and work-family supports, as well as housing and transportation, that may reduce EM [114]

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